Suicide Risk

Understanding and Responding

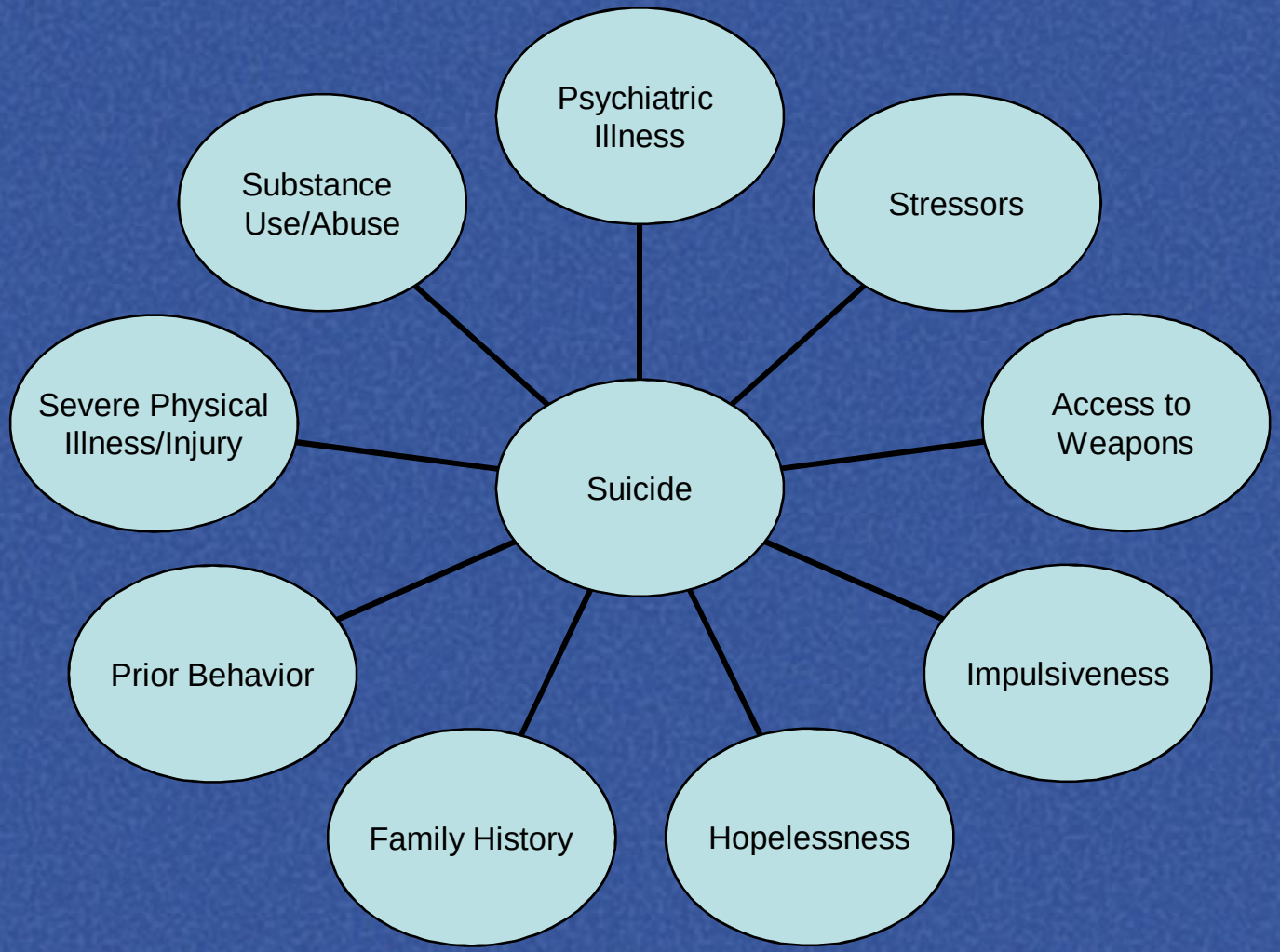
Douglas Jacobs, MD

President and CEO
Screening for Mental Health, Inc

Associate Clinical Professor of Psychiatry
Harvard Medical School

Today's Agenda

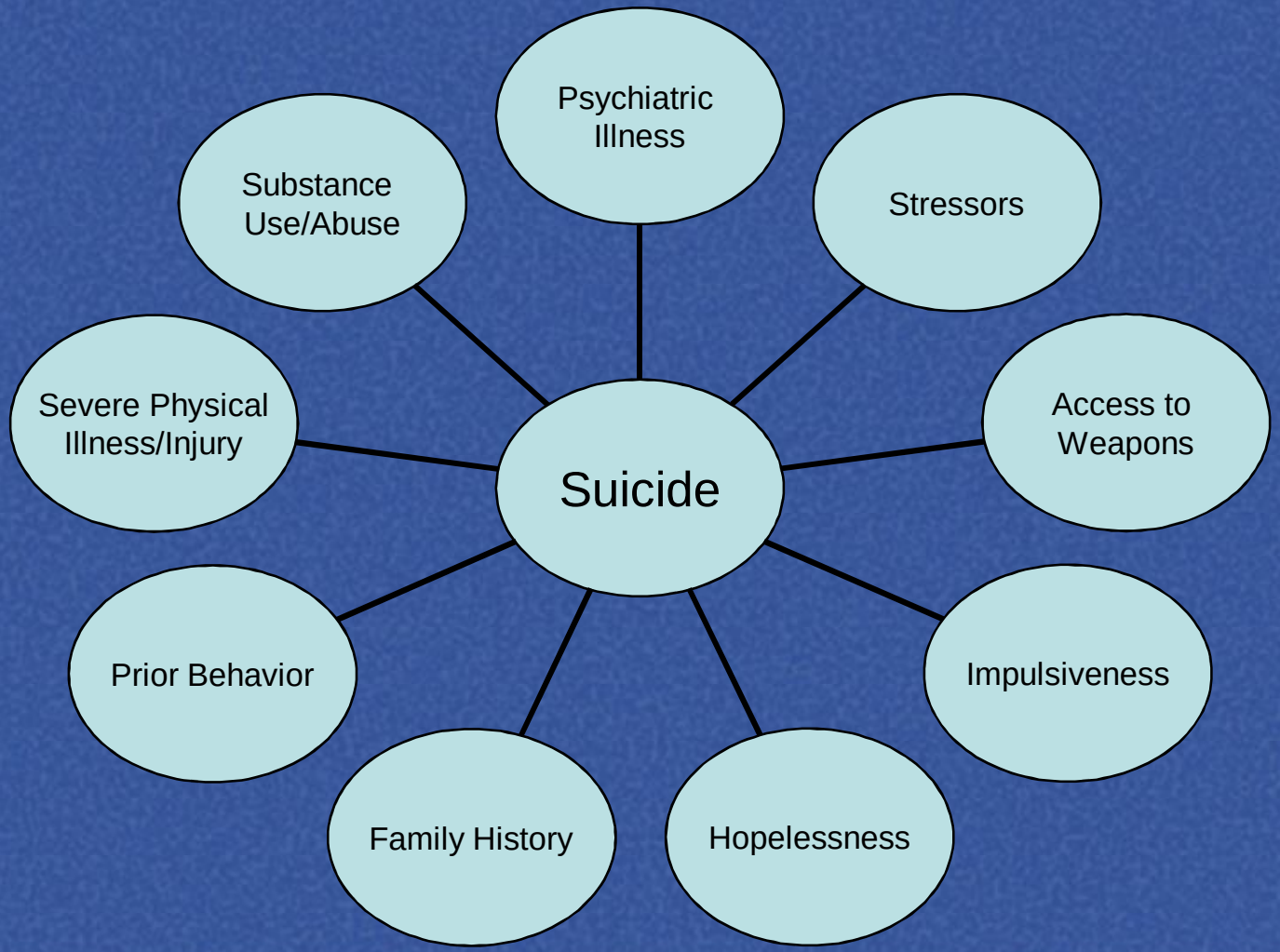
1. Review of Suicide Risk Factors
2. Identify your role
3. Learn interviewing methods
4. Determine when to get assistance
5. Discuss issues of confidentiality


Psychiatric Illness
Substance Use/Abuse
Stressors
Severe Physical Illness/Injury
Access to Weapons
Suicide
Prior Behavior
Impulsiveness
Family History
Hopelessness

Facts & Figures

- 90% to 95% have psychiatric illness
- 4:1 male to female for completions
- 3:1 female to male for attempts
- 60% completion on first attempt
- 50% never had psychiatric contact
- 25% in treatment
- 70% communicate intention to significant other

Suicide Risk Factors



Risk Factors

Interviewing Methods

Your Role

Assistance

Confidentiality

Psychiatric Illness

Current & Past Psychiatric Illness & Symptoms:

- Depression
- Psychosis (Disordered Thought Processes)
- Alcohol / substance abuse
- Cluster B Personality Disorders (Borderline P.D. and males with Antisocial P.D.)
- Post Traumatic Stress Disorder

Risk Increases With:

- Multiple Diagnoses
- Recent Onset/First Episode

Depression (Mood Disorders)

High-Risk Profile:

- Early in the course of illness
- Significant feelings of anxiety or panic
- Moderate alcohol abuse
- Risk for men is four times higher than women[1]
- 60% of suicides had been diagnosed with a mood disorder

1. Except in bipolar disorder where women are equally at risk

Alcohol & Substance Abuse

High-Risk Profile

- Recent onset
  - *Impact on relationships & career*
- Number of substances rather than type
- Additional psychiatric disorders
  - *Depressive symptoms*

PTSD

- Post Traumatic Stress Disorder
  - Lifetime rate in general population ~ 8%
  - Rate for Iraq War Veterans ~ 12-20%*
  - At least 41% of completed army suicides in 2007 were diagnosed with PTSD
- Symptoms of PTSD
  - Exposure to a traumatic stressor
  - Re-experiencing events
  - Avoidance and numbing symptoms
  - Symptoms of increased arousal (anxiety)
  - Significant distress or impairment of functioning

US Dept of Veterans Affairs NCPTSD, DSM-IV-TR, ASER 2007 *Expert estimates

Suicidal Behavior

Any previous suicidal behavior increases risk:

- History of prior suicide attempts
- Aborted suicide attempts
  - Stopped before actually injuring self
- Self-injurious behavior
  - Cutting
  - Burning

Family History

Risk increases with a family history of:

- Suicide – especially in close relatives
- Suicide Attempts
- Psychiatric Hospitalizations

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Stressors

Precipitants / Stressors:

- Separation or loss of significant relationship
- Events leading to significant feelings of
  - Humiliation
  - Shame
- Medical illness
  - Chronic pain
  - Disfigurement
  - Loss of function
- Intoxication

Access to Firearms

Access to Firearms Increases Risk:

"Whether or not a plan is present, if a patient has acknowledged suicidal ideation, there should be a specific inquiry about the presence or absence of a firearm in the home or workplace."

(APA Guidelines, Part A, pg. 11)

By definition, military service involves access to firearms.

Risk can be Reduced by Modifying Risk Factors

- Certain risk factors are “modifiable”
- They can be addressed to reduce risk in the short term
- Treatment planning can be guided by focusing on these factors

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Summary of Risk Factors

(Modifiable Factors Highlighted)

Demographic	male; widowed, divorced, single; increases with age; white
Psychosocial	lack of social support, unemployment, drop in socio-economic status, **firearm access**
Psychiatric	**psychiatric diagnosis**, comorbidity
Physical Illness	Cancer, HIV/AIDS, peptic ulcers, hemodialysis, chronic pain, diseases of nervous system
Psychological Dimensions	Hopelessness, psychic pain/anxiety, psychological turmoil, decreased self-esteem, fragile narcissism & perfectionism
Behavioral Dimensions	Impulsivity, aggression, severe anxiety, panic attacks, agitation, intoxication, **prior suicide attempt**
Childhood Trauma	sexual/physical abuse, neglect, parental loss
Genetic & Familial	family history of suicide, mental illness or abuse

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How Risk Factors are Modified

Environmental	Firearm access	Remove access (complicated in military setting)
Psychiatric	Psychiatric diagnoses (depression, substance abuse, PTSD, personality disorders)	Treatment with medications and psychotherapy
Psychological Dimensions	Hopelessness; psychic pain/anxiety; psychological turmoil; decreased self-esteem; fragile narcissism & perfectionism	Treatment with psychotherapy, behavioral therapy and medications
Behavioral Dimensions	Impulsivity; aggression; severe anxiety; panic attacks; agitation; intoxication	Treatment with psychotherapy, behavioral therapy and medications

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When to Ask About Suicide

- If the person mentions suicide or a wish for death
- If the person acts more depressed or hopeless
- If any suicidal or self-destructive behavior occurs
- If a significant change or stress occurs in their life
  - Separation from significant other
  - Career threatened

What the Client Might Say

- "I'm not sleeping well; I wake up very early."
- "I don't enjoy anything anymore."
- "I'm nervous all the time. I have panic attacks."
- Feelings of hopelessness or worthlessness:
  - "Nothing can help me."
  - "They would be better off without me."
- "Voices are telling me to end it all."
- Reports impulsive behavior such as more drinking and getting into fights.

How to Ask About Suicide

Begin with questions that address the patient's feelings about living.

- Have you ever felt that life is not worth living?
- Did you ever wish you could go to sleep and just not wake up?

Follow-up with specific questions about thoughts of death, self-harm, or suicide.

- Is death something you've thought about recently?
- Have things ever reached the point that you've thought about harming yourself?

(From the APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors)

"No, I'm Not Suicidal."

In a study of 76 inpatient hospital suicides, 78% denied suicidal ideation as their last communication with staff.

- Don't accept denial at face value
- If depressive symptoms are severe – especially anxiety, insomnia, loss of pleasure in everything – gently question why the patient does not feel suicidal
  - You sound like you feel hopeless; have you given up? Do you feel defeated?
  - You seem very sad; I'm worried…
  - What is it that keeps you from thinking about dying?
  - What would you do if you felt suicidal?
  - Ask about what keeps them going (reasons for living).

Asking about Homicide

Suicide risk can be associated with homicide risk especially in

- Postpartum women
- Possessive & paranoid men
  - May be dealing with loss or humiliation

Examples of questions to ask[1]:

- Are there others you think may be responsible for what you are feeling? Are you having any thoughts of harming them?
- Are there other people you would want to die with you?
- Are there others you think couldn't go on without you?

1. Adapted from the APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors

Chaplain

Chaplain	Likely first to hear about suicidal thoughts	Connect the person to the behavioral health service
Family Counselor	Likely first to hear about a spouse's worries (about themselves or their spouse)	Connect the potentially suicidal person or spouse to the chaplain or to behavioral health
Behavioral Health Professional	Conduct suicide assessment Refer for psychiatric evaluation	Provide counseling / treatment to reduce risk
Psychiatrist	Psychiatric evaluation Assess need for meds, hospitalization	Confirm assessment of suicide risk Provide treatment to reduce risk

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Family Counselor

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Behavioral Health Professional

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Facilitating Treatment Referral

- Listen and be accepting.
- Assume non-threatening stance.
- Reassure that help is available.
- Offer help.
- Accompany the person to behavioral health.

Emergency Situations

- Know your responsibilities and capabilities
- Know who to call for immediate intervention.
  - Have the names and numbers easily available.
- Be ready to make a tough call
  - Arranging for or mandating involuntary treatment.

Do Your Homework – Make a Safety Network

Answer these questions before a crisis situation

- What is my role in caring for suicidal clients?
- How do I interact with other caregivers?
- Do I know how to reach and refer to behavioral health?
- What is my role in an emergency situation?

Interrelationship of Helping Personnel

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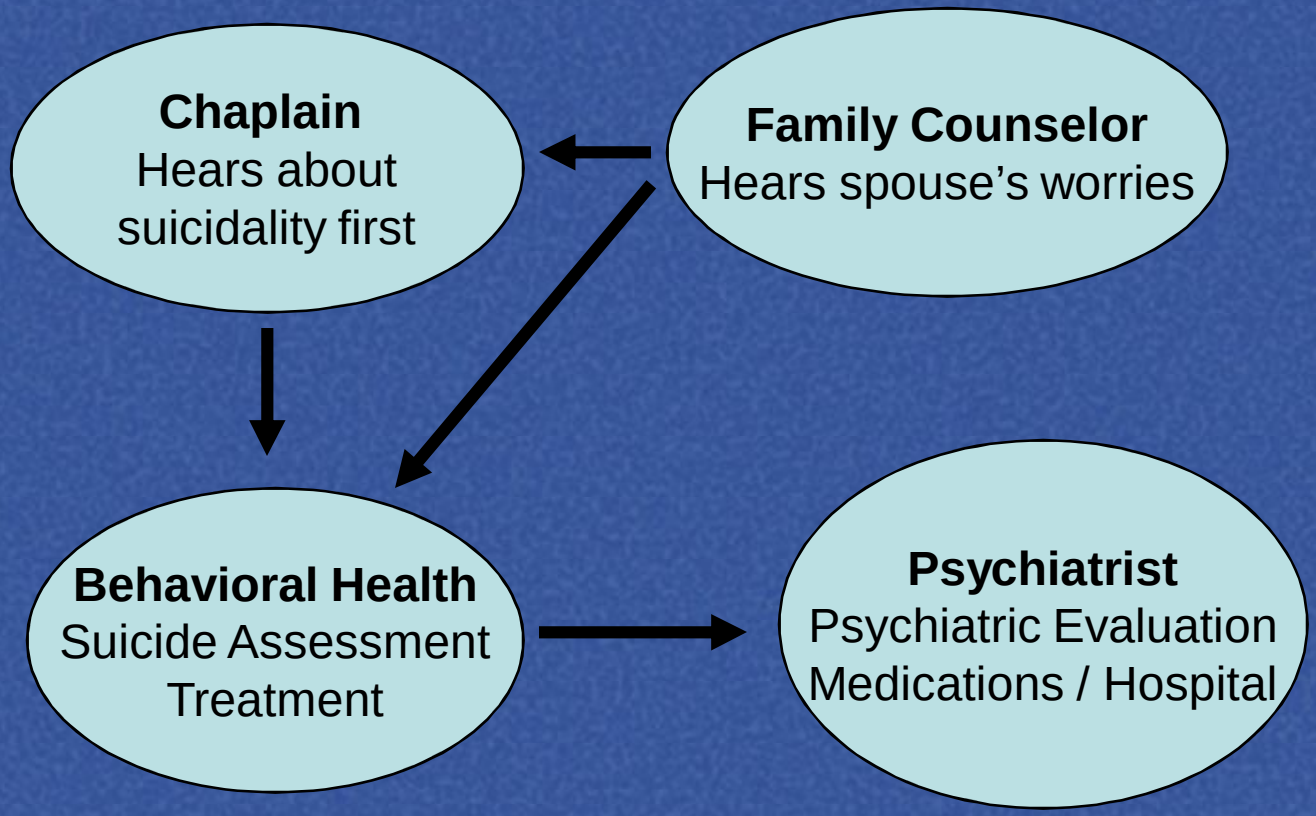

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Intervention Programs – A.C.E.

The Army's A.C.E. Program includes all crucial aspects of emergency intervention.

A. **Ask** directly if the person is thinking of suicide.

C. **Care** for the person. Remove means of self-harm. Calmly control the situation. Actively listen to provide relief.

E. **Escort** the person to the chain of command, Chaplain, behavioral health professional or primary care provider. Do not leave the person alone.

Confidentiality

- Promotes communication of important information.
- Fosters trust and alliance building.
- Can be voluntarily waived by the client and extended to other care-givers with permission
  - "May I talk with someone I trust about your situation?"
  - "I know someone whom I believe can help you more; will you come with me to discuss it with them?"
- Can always be extended to supervisor

Confidentiality: Understand How it Applies to You

- Chaplain Services usually adhere to strict confidentiality, but
  - It can be voluntarily waived by the client
  - It is extended to the supervisor
- Behavioral Health Professionals may breach confidentiality if they determine there is imminent risk of harm to self or other
  - Involuntary treatment may be necessary
  - Duty to warn may apply

Conclusions

- Familiarity with suicide risk factors allows you to recognize people who may be at risk
- Understanding your role and the roles of other caregivers allows you to seek and provide the most appropriate care for the suicidal person
- Make contact with other caregivers before a crisis
- Confidentiality does not need to be a barrier to helping the suicidal person